Audit Report

Saginaw County
Community Mental Health Authority

October 1, 2003 – September 30, 2004

Office of Audit

Fenton Regional Office

December 2007

JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
OFFICE OF AUDIT
400 S. PINE; LANSING, MI 48933

JANET OLSZEWSKI
DIRECTOR

December 21,2007

Phillip Grimaldt, Chairman, Board of Directors
Saginaw County Community Mental Health
500 Hancock Street
Saginaw, MI 48602-4292
and
Sandra M. Lindsey, Chief Executive Director
Saginaw County Community Mental Health
500 Hancock Street
Saginaw, MI 48602-4292
and
Ms. Janet Olszewski, Director
Department of Community Health
Capitol View Building – 7th Floor
Lansing, MI 48913

CERTIFIED MAIL
7004 2890 0001 2629 0914

Dear Mr. Grirnaldt, Ms. Lindsey, and Ms. Olszewski:

This is the final report from the Michigan Department of Community Health (MDCH) audit of the Saginaw County Community Mental Health, for the period October 1, 2003 through September 30,2004.

The final report contains the following: description of agency; funding methodology; purpose; objectives; scope and methodology; conclusions, findings and recommendations; financial status report; explanation of audit adjustments; contract reconciliation and cash settlement summary; and corrective action plans. The conclusions, findings, and recommendations are organized by audit objective. The corrective action plans include the agency's paraphrased response to the Preliminary Analysis, and the Office of Audit's response to those comments where necessary.

If the agency disagrees with the MDCH audit findings, the agency may use the dispute resolution process as specified in Section 3.16 of the Managed Specialty Supports and Services Contract (MSSSC), and/or the Medicaid Provider Reviews and Hearings. Both administrative remedies are described below.

If the agency chooses to engage Section 3.16 of the MSSSC (dispute resolution process), the agency must provide written notification to the MDCH of their intent within 30 days of receipt of this notice. The written notification must include the nature of, and any proposed resolution to, the dispute; and copies of ail relevant documentation. The final decision authority regarding disputes arising out of MDCH financial reviews and/or audits has been delegated to the MDCH Administrative Tribunal.

If the agency chooses to use the Medicaid Provider Reviews and Hearings, the agency must request a conference or hearing within 30 days of receipt of this notice. The adjustments presented in this final report are an adverse action as defined by MAC R 400.3401. If the agency disagrees with this adverse action, the agency has a right to request a preliminary conference, bureau conference or an administrative hearing pursuant to MCL 400.1 et seq. and MAC R 400.3401, et seq. The request should identify the specific audit adjustment(s) under dispute, explain the reason(s) for the disagreement, and state the dollar amount(s) involved, if any. The agency should also include any substantive documentary evidence to support their position. Requests must specifically identify whether the agency is seeking a preliminary conference, a bureau conference or an administrative hearing. If the agency does not appeal this adverse action within 30 days of receipt of this notice, this letter will constitute MDCH's Final Determination Notice according to MAC R 400.3405.

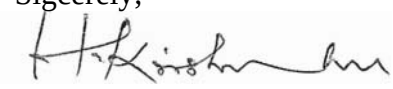
If the agency chooses to request a dispute. resolution process; and/or a preliminary conference, bureau conference, or administrative hearing, the request(s) must be sent within 30 days of receipt of this letter to:

Administrative Tribunal & Appeals Division
Michigan Department of Community Health
1033 S. Washington
P.O. Box 30763
Lansing, Michigan 48909

If MDCH does not receive a request for a preliminary conference, bureau conference, administrative hearing, or dispute resolution process within 30 days of receipt of this notice, MDCH will implement the adjustments as outlined in this final report.

Thank you for the cooperation extended throughout this audit process.

Sigcerely,



Hemachandran Krishnan, Regional Manager
Fenton Regional Office
Office of Audit

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DESCRIPTION OF AGENCY

The Saginaw County Community Mental Health Authority (SCCMHA) was originally established in 1978. In 1996, SCCMHA was reorganized as a mental health authority. SCCMHA operates under the provisions of Act 258 of 1974, the Mental Health Code, Sections 330.1001 – 330.2106. SCCMHA is subject to oversight by the Michigan Department of Community Health (MDCH).

SCCMHA provides inpatient, outpatient, residential, partial day, respite, management, prevention, emergency, and Omnibus Budget Reconciliation Act (OBRA) services to residents of Saginaw County.

SCCMHA's administrative offices are located in the City of Saginaw. SCCMHA's board consists of 12 members appointed for three-year terms by the County Board of Commissioners. The board members reside in Saginaw County.

FUNDING METHODOLOGY

SCCMHA contracted with MDCH under a Managed Mental Health Supports and Services Contract (MMHSSC) for FY 2003-04. This contract provided State General Funds (GF) for mental health and developmental disability supports and services to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in Section 208 of the Mental Health Code. SCCMHA received $6.9 million of GF funding in FY 2003-04. SCCMHA also contracted with MDCH under a Medicaid Managed Specialty Supports and Services Contract (MMSSSC). Under the MMSSSC, MDCH provided SCCMHA with both the state and federal share of Medicaid funds as capitated payments based on a Per Eligible Per Month (PEPM) methodology. SCCMHA received $30 million of Medicaid funding in FY 2003-04. SCCMHA also received special and/or designated funds, fee for service funds, MIChild,

and Adult Benefits Wavier (ABW) capitated funds under special contractual arrangements with MDCH. Each arrangement specifies the funding methodologies. MIChild is a non-Medicaid program designed to provide certain medical and mental health services for uninsured children of Michigan working families. MDCH also provided the funding for this program by capitated payments based on a Per Eligible Per Month methodology for covered services. The ABW provides health care benefits for Michigan's childless adult residents with income at or below 35% of the Federal Poverty Level. Unless otherwise noted in the Medicaid provider manuals, service coverage and authorization requirements for the fee-for-service (FFS) beneficiaries enrolled in the waiver program mirror those required by Medicaid.

PURPOSE AND OBJECTIVES

The purpose of this review was to determine whether the agency properly reported revenues and expenditures in accordance with generally accepted accounting principles and contractual requirements; to assess the agency's performance relative to the requirements and best practice guidelines set forth in the contracts; and to determine MDCH's share of costs in accordance with MDCH requirements and agreements.

Audit Objectives

1. FINANCIAL REPORTING

   To assess SCCMHA's effectiveness and efficiency in reporting their financial activity to MDCH in accordance with the MMHSSC and MMSSSC requirements; applicable federal, state, and local statutory requirements; Medicaid regulations; and applicable accounting standards.

2. CONTRACT AND BEST PRACTICE GUIDELINES COMPLIANCE

   To assess SCCMHA's effectiveness and efficiency in establishing and implementing specific policies and procedures, and in complying with the MMHSSC and MMSSSC requirements and best practice guidelines.

3. MDCH'S SHARE OF COSTS AND BALANCE DUE

To determine MDCH's share of costs in accordance with applicable MDCH requirements and agreements, and to identify any balance due to or from SCCMHA.

SCOPE AND METHODOLOGY

We examined SCCMHA's records and activities for the period October 1, 2003 through September 30, 2004. We also reviewed prior periods regarding depreciation of fixed assets. We completed an Internal Control Questionnaire to review internal controls relating to accounting for revenues and expenditures, procurement and other contracting procedures, reporting, claims management, and risk financing. We interviewed SCCMHA's finance director and other accounting and administrative personnel. We reviewed and evaluated SCCMHA's policies and procedures. We examined contracts for compliance with guidelines, rules, and regulations. We summarized and analyzed revenue and expenditure account balances to determine if they were properly reported on the Financial Status Report (FSR) in compliance with the MMHSSC and MMSSSC reporting requirements and applicable accounting standards. We performed our audit procedures from March 2005 through June 2005.

CONCLUSIONS, FINDINGS, AND RECOMMENDATIONS

FINANCIAL REPORTING

Objective 1: To assess SCCMHA's effectiveness and efficiency in reporting their financial activity to MDCH in accordance with the MMHSSC and MMSSSC requirements; applicable federal, state, and local statutory requirements; Medicaid regulations; and applicable accounting standards.

Conclusion: SCCMHA was not effective and efficient in reporting their financial activity to MDCH as required by the MMHSSC and MMSSSC, applicable statutory requirements, Medicaid regulations, and applicable accounting standards. We found differences between the FSR and the trial balance (finding 1), over accrued MIS costs (finding 2), capital assets not properly depreciated (finding 3), and an improper contribution to the Internal Service Fund (finding 4).

Finding

1. Differences Between the FSR and the Trial Balance

SCCMHA did not report their revenues and expenditures correctly on the FSR as compared to the amounts stated in their trial balance, which is in violation of the MMSSSC and MMHSSC.

Paragraph 2.3.1 of the MMSSSC, Attachment P 7.8.1, and the MMHSSC, Attachment C 7.8.1, states:

> ***Column C: Accrued YTD Actual***
>
> *The amounts entered in this column are expected to represent year-to-date revenues received and/or accrued for the time period of the report. The amounts entered must include all earned reimbursements regardless of whether these have been billed or collected…*

Paragraph 2.4.2 of the MMSSSC, Attachment P 7.8.1, and the MMHSSC, Attachment C 7.8.1, states:

> ***Column C: YTD Actual – Accrual Accounting Basis***
>
> *The amounts entered in this column are expected to be on an accrual accounting basis for the time period of the report. This is to represent actual expenditures and expenditure obligations.*

During our reconciliation between the FSR and the trial balance, we identified a number of differences that can be grouped into three major problem areas:

(1) The FSR, Expenditures, Line A, Gross Total Expenditures had a mathematical error. Lines B through I of the expenditure section add up to $40,102,324. However, SCCMHA reported $40,249,324 on line A of the expenditures section of the FSR, overstating total expenditures by $147,000. SCCMHA later revised this amount to $40,102,324 in the FSRs submitted after the completion of the audit, including the final revised FSR dated March 28, 2006.

(2) Several line items on the FSR did not agree with the trial balance. Overstatements included: Expenditures Not Otherwise Reported for $50,301 and MDCH Earned Contracts for $20,441. Understatements included: Local Total for $1,007 and Matchable Expenditures for $69,735. These overstatements and understatements netted out to zero.

(3) The FSR, Revenue, Line A, Revenues Not Otherwise Reported was overstated when compared to the amounts in the trial balance. SCCMHA reported $143,711 in Revenues Not Otherwise Reported, but the amounts on the trial balance added to $134,408 for a difference of ($9,303).

Audit adjustments correcting the overstatements and understatements in both expenditures and revenues are shown on Schedules A and B of this report. Additionally, the mathematical error of $147,000 in line A of the expenditure section of the FSR will also be corrected.

Recommendation:

We recommend that SCCMHA implement policies and procedures that include a reconciliation between the FSR and trial balance to ensure accuracy of the line items prior to submission to MDCH in compliance with the MMSSSC and MMHSSC.

Finding

2. Over Accrued MIS Costs

SCCMHA overstated their management information systems (MIS) costs by $31,752. We reviewed the billings for MIS services from Bay-Arenac CMH. The invoices totaled $133,655. However, SCCMHA recorded $169,123 as expense. We questioned SCCMHA personnel about this discrepancy on May 9, 2005. SCCMHA personnel stated that they over-accrued the expense and intended to reverse the over accrual in FY 9/30/2005. SCCMHA subsequently provided documentation that $3,716 was reversed in FY 9/30/2005.

Part 1.3 Financial Status Report, of the MMHSSC, Attachment C 7.8.1 and the MMSSSC, Attachment P 7.8.1, states,

> *With the exception of P.A. 423 Grant Funds, all reported revenue and expenditure information is required to be provided on an accrual basis of accounting. The accrual basis is expected to recognize all revenues and expenditures through the reporting periods.*

Adjustments correcting the over accrual are shown on Schedules A and B of this report.

Recommendation:

We recommend that SCCMHA establish policies and procedures to ensure accruals are more accurately calculated and adjustments for over or under accruals are more timely.

Finding

3. Capital Assets Not Properly Depreciated

SCCMHA did not properly depreciate capital assets in compliance with Office of Management and Budget (OMB) Circular A-87 and contract provisions.

Section 6.6.1 of the MMSSSC and the MMHSSC, states, in pertinent part:

> *The [PIHP/CMHSP] shall maintain all pertinent financial and accounting records and evidence pertaining to this contract based on financial and statistical records that can be verified by qualified auditors. The [PIHP/CMHSP] will comply with generally accepted accounting principles (GAAP) for governmental units when preparing financial statements. The [PIHP/CMHSP] will use the principles and standards of OMB Circular A-87 for determining all costs…reported on the financial status report.*

OMB Circular A-87, Attachment B, Section 11. Depreciation and use allowances, states, in part,

a. *Depreciation and use allowances are means of allocating the cost of fixed assets to periods benefiting from asset use. Compensation for the use of fixed assets on hand may be made through depreciation or use allowance…*
c. *The computation of depreciation or use allowances will exclude: (1) The cost of land…*
d. *Where the depreciation method is followed, the period of useful service (useful life) established in each case for usable capital assets must take into consideration such factors as type of construction, nature of the equipment used, historical usage patterns, technological developments, and the renewal and replacement policies of the governmental unit followed for the individual items or classes of assets involved…*

During our review of the depreciation lapse schedule, we noted that SCCMHA established much shorter useful lives for their capital assets than what appeared appropriate. For example, in FY 2003-04, SCCMHA purchased a group home for

$165,000 and established a useful life of 15 years. However, for this type of structure, the American Hospital Association (AHA) guidelines recommend a useful life of 25 years. Furthermore, SCCMHA included in their computation of depreciation the cost of land at $30,000, which should not be depreciated.

Applying the useful lives recommended by the AHA guidelines to SCCMHA's capital assets and removing the cost of land from the depreciation calculation, we determined that depreciation was overstated by $138,148 in FY 2003-04.

Adjustments reducing depreciation expense by $138,148 appear on Schedules A and B of this report.

Recommendation:

We recommend that SCCMHA adjust the useful lives of fixed assets in their depreciation calculation to adhere to AHA guidelines, and to establish policies and procedures to use AHA guidelines in determining the useful lives of any fixed assets purchased in the future, in compliance with OMB Circular A-87.

Finding

4. Improper Contribution to the Internal Service Fund

SCCMHA reported a $400,000 contribution to the Internal Service Fund (ISF) without evidence that the estimated liability in the ISF was based on sound actuarial principles using historical experience and reasonable assumptions as provided under OMB Circular A-87, which is in violation of contract provisions.

SCCMHA made a $400,000 contribution to the Medicaid ISF in FY 2003-04. SCCMHA did not have an actuary report to support the contribution.

The MMSSSC, Attachment P 7.7.4.1, Internal Service Fund Technical Requirement, states the following under General Provisions:

C. *When establishing an ISF, the CMHSP may apply any method it considers appropriate to determine the amounts to be charged to the various funds covered by the ISF provided that:*

   1. *The total amount charged to the various funds does not exceed the amount of the estimated liability determined pursuant to Governmental Accounting Standards Board (GASB) Statement No. 10, General Principles of Liability Recognition, or such other authoritative guidance as issued by the American Institute of Certified Public Accountants (AICPA); and*
   2. *The estimated liability is computed based on an actuarial method or historical cost information as provided under Office of Management and Budget (OMB) Circular A-87, Attachment B, paragraph 25(d)…*

D. *Non-compliance with the provisions of GASB Statement No. 10 and OMB Circular A-87 relative to any applicable matter herein will cause the ISF charges to be unallowable for the purposes of the MDCH/CMHSP Contract.*

OMB Circular A-87, Attachment B, paragraph 25(d)(3), (paragraph 22 effective June 9, 2004) states,

Contributions to reserves must be based on sound actuarial principles using historical experience and reasonable assumptions. Reserve levels must be analyzed and updated at least biennially for each major risk being insured and take into account any reinsurance, coinsurance, etc.

The most recent actuary report that SCCMHA had was from the year 2001. SCCMHA did not have an updated actuary report to support the current balance in the ISF. Thus, any contributions to the ISF would not be allowable. Accordingly, adjustments removing the $400,000 contribution are included on Schedules A and B of this report.

Recommendation:

We recommend that SCCMHA adopt policies and procedures to ensure that any ISF contributions comply with contract provisions, and the ISF balance is analyzed and updated at least biennially as required by contract and OMB Circular A-87 provisions.

CONTRACT AND BEST PRACTICE GUIDELINES

Objective 2: To assess SCCMHA's effectiveness and efficiency in establishing and implementing specific policies and procedures, and in complying with the MMSSSC, the MMHSSC, and best practice guidelines.

Conclusion: SCCMHA was generally effective and efficient in complying with the MMSSSC and MMHSSC requirements and best practice guidelines. However, our assessments disclosed exceptions related to the lack of monitoring of consumer funds (finding 5), inadequate monitoring of personal care services (finding 6), improper personal care payments (finding 7), internal control weaknesses (finding 8), and improper financial reporting (findings 1-4).

Finding

5. Lack of Monitoring of Consumer Funds

SCCMHA did not implement and properly monitor effective accounting policies to properly account for resident funds at residential providers under contract, which is a violation of the Licensing Rules for Adult Foster Care Small Group Homes issued by the State of Michigan Department of Consumer and Industry Services (Licensing Rules).

The review of consumer funds held in trust yielded an audit recommendation for improvements in the internal control procedures of the individual homes and their corporate operators. The following are instances in which consumer funds were not properly recorded.

On June 2, 2005, we went to six homes, including Rambo House, to review consumer funds. For one consumer, Rambo House maintained two ledger cards for the same time period. One ledger card (ledger card A) had expenditures on May 7 for weekend activities for $5.00, on May 12 for school activity for $5.75, and on May 22 for weekend activity for $1.48. These entries were initialed by both the consumer and by an employee. None of these activities were entered on the other ledger card (ledger card B). An expenditure on May 13 in the amount of $33.00 for shopping was also entered on ledger card A. Although this entry was entered on ledger card B, a different employee initialed it. An expenditure on May 16 for bowling in the amount of $5.00 was entered on ledger card B. This entry was not entered on ledger card A. The balance on ledger card A was $4.25. The balance on ledger card B was $11.48. When we removed all expenditures that were not entered on both ledger cards, the balance would be negative $0.75. We counted $5.64 in the consumer's envelope.

For another consumer, we reviewed one set of three ledger cards covering the period 7/23/2004 through 5/7/2005. The first ledger card, covering the period 7/23/2004 through 12/9/2004, had one license number and the other two ledger cards had a different license number. According to the state website, the license number on the first ledger card was invalid and the license number on the other two ledger cards was proper.

There were numerous mathematical errors on the ledger cards. On 12/9/2004, one consumer's ledger card showed a balance of $39.20. On that date, there was a deposit of $25.00 and a withdrawal of $5.00 recorded on the same line of the ledger card, with no explanation. Therefore, the balance should be $59.20. However, the ledger card had a balance of $64.20. There were several other instances of similar mathematical errors. Considering the numerous errors made on the ledger cards, the ledger cards should be substantially different than the cash on hand. However, when we counted the cash as of 6/2/05, the amount in the consumer's envelope was exactly the same amount as the balance shown on the ledger card.

We attempted to reconcile the amounts in the consumers' savings accounts with the ledger cards as maintained by Rambo House. Two consumers at Rambo House had savings accounts. However, Rambo House did not maintain any ledger cards for the savings accounts. We then attempted to trace the withdrawals from the consumers' savings accounts to the cash accounts. One consumer had two savings withdrawals of $250.00 and $40.00, which were never recorded in the consumer's cash ledger card as received by the consumer. Another consumer had a savings withdrawal of $300.00, which was never recorded in the cash ledger card as received by the consumer. There was no other documentation that accounted for the disposition of these withdrawals.

We attempted to trace the withdrawals from the cash account to the receipt of purchase for one consumer. We found numerous instances where receipts for consumer purchases did not agree with the entries on the consumer's ledger card.

Another consumer had a balance of $13.21 as of 4/14/2005 (the date of the last entry on the ledger card). In the consumer's envelope there was a record of a deposit made after 4/14/2005 in the amount of $40.00. There were also receipts for expenditures made after 4/14/2005 in the amount of $32.50. Therefore, the balance as of 6/2/2005 should be $20.71. However, when we counted the cash, the consumer had $20.93 in her envelope.

Licensing Rule 400.14315, Handling of Resident Funds and Valuables, sub-section (1), states:

> *Upon a request from a resident or the resident's designated representative, a licensee may accept a resident's funds and valuables to be held in trust with the licensee.*

Sub-section (2) states,

> *The care of any resident funds and valuables that have been accepted by a licensee for safekeeping shall be treated by the licensee as a trust obligation.*

Sub-section (13) states,

> *A licensee shall provide a complete accounting, on an annual basis and upon request, of all resident funds and valuables which are held in trust…*

Rambo House did not properly account for resident funds and SCCMHA did not establish and implement effective policies and procedures to ensure against misappropriation.

Recommendation:

We recommend that SCCMHA establish and implement policies and procedures to ensure that resident funds are safeguarded against misappropriations by periodically reviewing resident funds, and by implementing punitive actions, where funds are not properly accounted for.

Finding

6. Inadequate Monitoring of Personal Care Services

SCCMHA was not effective in monitoring personal care services provided by the residential providers to ensure that personal care services were provided as required in the consumers' Individual Plans of Service (IPS), which violates the MMSSSC.

We reviewed personal care payments and the supporting documentation for ten consumers for the month of April 2005. Personal care logs, as maintained by the homes, did not agree with the IPS in four instances. In one instance a consumer did not receive personal care for bathing, transferring, or ambulating, as required by that consumer's IPS. The home manager informed us that the consumer could walk on her own and didn't need personal care with transferring or ambulating. In another instance, a consumer did not receive personal care with ambulating, as required in his IPS. In both the aforementioned instances, the personal care logs indicated that the consumers received personal care for services not required in their IPS. In another instance, a consumer did not receive personal care with eating, as required in her IPS. In another instance, a consumer did not receive personal care with bathing as required in his IPS. The home manager informed us that bathing was not in this consumer's IPS.

The MMSSSC, Attachment 6.8.2.4, Paragraph V. E., states,

> *Provider of service must maintain a service log that documents specific days on which personal care services were delivered consistent with the recipient's Individual Plan of Service.*

The MMSSSC, Attachment 6.8.2.4, Paragraph III, states,

> *Upon placement of a mental health recipient into a non-specialized residential foster care setting, the Responsible Mental Health Agency (RMHA) shall insure that any need for personal care services as identified in their plan is addressed in keeping with Medicaid (MA) standards. In addition, RMHA shall take the required action(s) to further insure that payment(s) for personal care services are issued, and all payment problems are resolved.*

Similar language is found in the Community Mental Health Services Program Manual, Chapter III. SCCMHA did not ensure that recipients received the person care as required in their IPS.

Recommendation:

We recommend that SCCMHA establish and implement personal care policies and procedures to ensure that personal care services are provided in accordance with the IPS, in compliance with the MMSSSC, Attachment 6.8.2.4, and the Community Mental Health Services Program Manual, Chapter III.

Finding

7. Improper Personal Care Payments

SCCMHA was not effective in monitoring personal care payments for their consumers, which is in violation of the MMSSSC.

As stated in finding #6, we reviewed personal care payments for the month of April 2005 for ten consumers. When the contract manager of SCCMHA called one home, Diane's

Adult Foster Care (AFC), to arrange for the auditor's review of the personal care records on one consumer, he was informed that the consumer had died a year ago.

Upon further investigation, we determined that the consumer left Diane's AFC on 9/13/2004. The consumer was admitted to a hospital on 9/27/2004. We found no other evidence that the consumer was ever re-admitted to any other AFC home. The consumer passed away on 4/16/2005.

The Family Independence Agency (FIA) paid Diane's AFC for personal care services seven months after the consumer was discharged from the home and for fourteen days after she died. SCCMHA stated that the money was paid back to FIA, but presented no documentation to that effect.

The MMSSSC, Attachment 6.8.2.4, Paragraph III, states,

> *Upon placement of a mental health recipient into a non-specialized residential foster care setting, the Responsible Mental Health Agency (RMHA) shall insure that any need for personal care services as identified in their plan is addressed in keeping with Medicaid (MA) standards. In addition, RMHA shall take the required action(s) to further insure that payment(s) for personal care services are issued, and all payment problems are resolved.*

It is the responsibility of SCCMHA to ensure that personal care payments are properly made for actual personal care services rendered to consumers. Additionally, when payments are found to be unnecessary and/or improper, adequate documentation needs to be maintained in order to account for any refunds issued by the AFC.

Recommendation:

We recommend that SCCMHA implement effective monitoring policies and procedures to ensure that personal care services are provided for personal care payments received and to ensure that improper payments are refunded, in compliance with the MMSSSC.

Finding

8. Internal Control Weaknesses

SCCMHA did not establish and implement effective internal controls to protect its assets.

SCCMHA did not take a physical inventory of furniture and equipment. Also, SCCMHA did not use pre-numbered purchase orders.

A physical inventory is needed to properly track capital assets, support depreciation expense, and detect employee theft. Without a physical inventory, it is difficult to know if any furniture or equipment is missing. Additionally, pre-numbered purchase orders are needed to properly track authorized purchases. Without the pre-numbered purchase orders, an employee could make unauthorized purchases without being detected, as no one would know that any purchase orders are missing.

Paragraph 6.6.1 of the MMSSSC and MMHSSC states,

The [PIHP/CMHSP] shall maintain adequate internal control systems.

Recommendation:

We recommend that SCCMHA establish and implement an adequate internal control system in compliance with the MMSSSC and MMHSSC that includes an annual inventory of furniture and equipment and the use of pre-numbered purchase orders.

MDCH'S SHARE OF COSTS AND BALANCE DUE MDCH

Objective 3: To determine MDCH's share of costs in accordance with applicable MDCH requirements and agreements, and to identify any balance due to/from MDCH.

Conclusion: MDCH's obligation (excluding the MIChild and Adult Benefit Waiver capitated funds, MDCH Earned Contracts, and Children's Waiver) is $37,082,564 for FY 2004. SCCMHA owes MDCH a balance of $491,560 for FY 2004 after considering advances and adjusting for prior settlements as shown on Schedule C of this report. However, $374,641 may be retained by SCCMHA as additional Medicaid savings as a result of audit adjustments if SCCMHA includes the Medicaid savings in a Reinvestment Strategy as required by Sections 7.7.2.1 and 7.7.2.2 of the MMSSSC. SCCMHA also owes MDCH $24,895 for audit adjustments to MDCH Earned Contracts (findings 1, 2 & 3).

Schedule A
Financial Status Report
October 1, 2003 through September 30, 2004

	REVENUES	Reported Amount	Audit Adjustments	Adjusted Amount
A.	Revenues Not Otherwise Reported	$ 143,711	$ (9,303)	$ 134,408
C.	Earned Contracts (non DCH) Total	$ 3,201	$ -	$ 3,201
1	CMH to CMH	-	-	-
2	Other	3,201	-	3,201
3	Medicaid Managed Care - CMHSP Affiliate	-	-	-
D.	MI Child - Mental Health	$ 27,846	$ (86)	$ 27,760
D1	Adult Waiver Benefit	$ 1,233,440	$ (171)	$ 1,233,269
E.	Local Funding Total	$ 1,408,795	$ -	$ 1,408,795
1	Special Fund Account (226(a))	198,099	-	198,099
2	Title XX Replacement	38,673	-	38,673
3	All Other	1,172,023	-	1,172,023
4	Affiliate Local Cont to State Mcaid Match Provider from CMHSP	-	-	-
F.	Reserve Balances - Planned for use	$ 759,660	$ -	$ 759,660
1	Carryforward -Section 226(2)(b)(c)	191,285	-	191,285
2	Medicaid Savings	-	-	-
2a	Medicaid Savings - Substance Abuse	58,441	-	58,441
3	Internal Service Fund – Abatement	-	-	-
4	Internal Service Fund - Risk Corridor	300,000	-	300,000
5	Other (205(4)(h)	209,934	-	209,934
6	Stop/loss Insurance	-	-	-

Schedule A
Financial Status Report
October 1, 2003 through September 30, 2004

	REVENUES	Reported Amount	Audit Adjustments	Adjusted Amount
G.	DCH Earned Contracts Total	$ 547,152	$ -	$ 547,152
1	PASARR	369,451	-	369,451
2	Block Grant for CMH Services	8,310	-	8,310
3	DD Council Grants	-	-	-
4	PATH/Homeless	61,769	-	61,769
5	Prevention	-	-	-
6	Aging	-	-	-
7	HUD Shelter Plus Care	-	-	-
8	Other DCH Earned Contracts	107,622	-	107,622
H.	Gross Medicaid Total	$ 30,097,653	$ 224,945	$ 30,322,598
1	Medicaid - Specialty Managed Care	30,026,263	(32,435)	29,993,828
2	Medicaid - Children's Waiver Total	71,390	257,380	328,770
I.	Reimbursements Total	$ 851	$ -	$ 851
1	1st and 3rd Party	-	-	-
2	SSI	$ 851	$ -	$ 851
J.	State General Funds Total	$ 6,928,366	$ -	$ 6,928,366
1	Formula Funding	2,646,114	-	2,646,114
2	Categorical Funding	129,248	-	129,248
3	State Services Base	4,153,004	-	4,153,004
K.	Grand Total Revenues	$ 41,150,675	$ 215,385	$ 41,366,060
L.	Estimated MDCH Obligation (D+D1+H+J)	$ 38,287,305	$ 224,688	$ 38,511,993

Schedule A
Financial Status Report
October 1, 2003 through September 30, 2004

	EXPENDITURES	Reported Amount	Audit Adjustments	Adjusted Amount
A.	Gross Total Expenditures	$ 40,249,324	$ (716,316)	$ 39,533,008
B.	Expenditures Not Otherwise Reported	$ 195,090	$ (59,318)	$ 135,772
D.	Earned Contracts (Non MDCH) Total	$ 3,201	$ -	$ 3,201
1	CMH to CMH	-	-	-
2	Other Earned Contracts	3,201	-	3,201
3	Medicaid Managed Care Affiliate	-	-	-
F.	Local Total	$ 1,110,843	$ 1,007	$ 1,111,850
1	Local Cost for State Provided Services	601,194	1,007	602,201
2	Other Not Used as Local Match	-	-	-
3	Local Match	-	-	-
4	PIHP Contribution to State Medicaid Match Provided to DCH	509,649	-	509,649
G.	Expenditures From Reserve Balances	$ 249,726	$ -	$ 249,726
1	Carryforward - Sec 226(2)(b)(c)	191,285	-	191,285
2	Medicaid Savings	-	-	-
2a	Medicaid Savings – Substance	58,441	-	58,441
3	Internal Service Fund	-	-	-
4	Other (205(4)(h))	-	-	-
5	Stop/Loss Ins.	-	-	-

Schedule A
Financial Status Report
October 1, 2003 through September 30, 2004

	EXPENDITURES	Reported Amount	Audit Adjustments	Adjusted Amount
H.	MDCH Earned Contracts Total	$ 606,813	$ (24,895)	$ 581,918
1	PASARR	381,813	(16,074)	365,739
2	Block Grant for CMH Services	8,310	-	8,310
3	DD Council Grants	-	-	-
4	PATH/Homeless	100,773	(442)	100,331
5	Prevention	-	-	-
6	Aging	-	-	-
7	HUD Shelter Plus Care	-	-	-
8	Other MDCH Earned Contracts	115,917	(8,378)	107,539
I.	Matchable Services (A-(B through H))	$ 37,936,652	$ (486,110)	$ 37,450,542
J.	Payments to MDCH for State Services	$ 4,823,841	$ 1,565	$ 4,825,406
K.	Specialty Managed Care Service Total	$ 28,705,631	$ (537,788)	$ 28,167,843
1	100% MDCH Matchable Services	28,705,631	(537,788)	28,167,843
2	All SSI and Other Reimbursements	-	-	-
3	Net MDCH Share for 100 % Services (K1-K2)	28,705,631	(537,788)	28,167,843

Schedule A
Financial Status Report
October 1, 2003 through September 30, 2004

	EXPENDITURES	Reported Amount	Audit Adjustments	Adjusted Amount
L.	GF Categorical and Formula Services Total	$ 3,561,045	$ 39,536	$ 3,600,581
1	100% MDCH Matchable Services	607,344	(13,552)	593,792
2	All SSI and Other Reimbursements	851	-	851
3	Net GF and Formula for 100% Services (L1-L2)	606,493	(13,552)	592,941
4	90/10 Matchable Services	2,953,701	53,088	3,006,789
5	Reimbursements	-	-	-
6	10% Local Match Funds	295,370	5,309	300,679
7	Net GF and Formula for 90/10 Services (L4-L5-L6)	2,658,331	47,779	2,706,110
8	Total MDCH GF and Formula (L3+L7)	3,264,824	34,227	3,299,051
La	MIChild Mental Health	$ 27,846	$ 11,021	$ 38,867
1	MIChild Mental Health - Capitation - Medicaid Only	27,846	(981)	26,865
2	MIChild Mental Health - MDCH GF Operations Base	-	12,002	12,002
Lb	Adult Benefit Waiver	$ 410,969	$ (443)	$ 410,526
1	ABW - Capitation - Medicaid and State Match	410,969	(443)	410,526
2	ABW - MDCH GF Operations Base	-	-	-
M.	Children's Waiver – Total	$ 407,320	$ -	$ 407,320
1	Medicaid	407,320	(78,550)	328,770
2	Other Reimbursements	-	78,550	78,550
3	MDCH GF Operations Base	-	-	-
O.	Total Local Match Funds (F+L6)	$ 1,406,213	$ 6,316	$ 1,412,529
P.	Total MDCH Share of Expenditures (J+K3+L8+La+Lb+M1+M3)	$ 37,640,431	$ (569,968)	$ 37,070,463

Schedule B

Explanation of Audit Adjustments

October 1, 2003 through September 30, 2004

Revenues Not Otherwise Reported	**($9,303)**
To adjust FSR to general ledger (finding 1)	
MI Child – Mental Health	**($86)**
To adjust MI Child revenue to amount reported by MDCH (per final settlement)	
Adult Benefits Waiver	**($171)**
To adjust ABW revenue to amount reported by MDCH (per final settlement)	
Medicaid Specialty Managed Care	**($32,435)**
To adjust Medicaid revenue to amount reported by MDCH (per final settlement)	
Medicaid – CW Total	**$257,380**
To adjust Children's Waiver revenue to amount reported on revised FSR (per final settlement)	

Schedule B (continued)

Gross Total Expenditures	**($716,316)**
($147,000) to adjust FSR to general ledger (finding 1)	
($31,752) to adjust MIS costs to amounts per invoices (finding 2)	
($138,148) to adjust depreciation by using useful lives in accordance with AHA guidelines (finding 3)	
($400,000) to disallow ISF contribution due to lack of actuary report (finding 4)	
$1,565 to adjust payments to MDCH for state services to amount reported by MDCH (per final settlement)	
($981) to adjust MIChild expense to amount on revised FSR (per final settlement)	
Expenditures Not Otherwise Reported	**($59,318)**
($50,301) to adjust FSR to general ledger (finding 1)	
($9,017) to adjust depreciation by using useful lives in accordance with AHA guidelines (finding 3)	
Local Total	**$1,007**
To adjust FSR to general ledger (finding 1)	
MDCH Earned Contracts Total	**($24,895)**
($20,441) to adjust FSR to general ledger (finding 1)	
($1,636) to adjust MIS costs to amounts per invoices (finding 2)	
($2,818) to adjust depreciation by using useful lives in accordance with AHA guidelines (finding 3)	

Schedule B (continued)

Matchable Services	**($486,110)**
$69,735 to adjust FSR to general ledger (finding 1)	
($30,116) to adjust MIS costs to amounts per invoices (finding 2)	
($126,313) to adjust depreciation by using useful lives in accordance with AHA guidelines (finding 3)	
($400,000) to disallow ISF contribution due to lack of actuary report (finding 4)	
$1,565 to adjust payments to MDCH for state services to amount reported by MDCH (per final settlement)	
($981) to adjust MIChild expense to amount on revised FSR (per final settlement)	
Payment to MDCH for State Services	**$1,565**
To adjust payments to MDCH for state services to amount reported by MDCH (per final settlement)	
Specialty Managed Care Services Total – 100% Matchable Services	**($537,788)**
($24,227) to adjust MIS costs to amounts per invoices (finding 2)	
($113,561) to adjust depreciation by using useful lives in accordance with AHA guidelines (finding 3)	
($400,000) to disallow ISF contribution due to lack of actuary report (finding 4)	
GF Categorical and Formula Funding	**$39,536**
$69,735 to adjust FSR to general ledger (finding 1)	
($5,757) to adjust MIS costs to amounts per invoices (finding 2)	
($12,440) to adjust depreciation by using useful lives in accordance with AHA guidelines (finding 3)	
($12,002) to report 30.88% of MI Child expenditures as GF – Operations Base (per final settlement)	

Schedule B (continued)

100% MDCH Matchable Services	**($13,552)**
($1,761) to adjust FSR to general ledger (finding 1)	
($106) to adjust MIS costs to amounts per invoices (finding 2)	
$317 to adjust depreciation by using useful lives in accordance with AHA guidelines (finding 3)	
($12,002) to report 30.88% of MIChild expenditures as GF – Operations Base (per final settlement)	
90/10 Matchable Services	**$53,088**
$71,496 to adjust FSR to general ledger (finding 1)	
($5,651) to adjust MIS costs to amounts per invoices (finding 2)	
($12,757) to adjust depreciation by using useful lives in accordance with AHA guidelines (finding 3)	
MIChild Mental Health – Capitation – Medicaid Only	**($981)**
To adjust MIChild expense to amount on revised FSR (per final settlement)	
MIChild Mental Health – MDCH GF Operations Base	**$12,002**
To report 30.88% of MIChild expenditures as GF –Operations Base (per final settlement)	
Adult Benefits Waiver	**($443)**
($132) to adjust MIS costs to amounts per invoices (finding 2)	
($311) to adjust depreciation by using useful lives in accordance with AHA guidelines (finding 3)	
Children's Waiver – Medicaid	**($78,550)**
To separate children's waiver expenditures funded by other Reimbursements (per final settlement)	
Children's Waiver – Other Reimbursements	**$78,550**
To separate children's waiver expenditures funded by other Reimbursements (per final settlement)	

Schedule C
Contract Reconciliation and Cash Settlement Summary
October 1, 2003 through September 30, 2004

I.	Specialized Managed Care (Includes both state and federal share)	MDCH Revenue	MDCH Expense
A.	Total - Specialized Managed Care	$ 29,993,828	$ 28,167,843
II.	State/General Fund Formula Funding		
A.	GF/Formula - State and Community Managed Programs	Authorization	MDCH Expense
1	State Managed Services	$ 4,153,004	$ 4,825,406
2	MDCH Risk Authorization – MDCH Approved for Use	-	-
3	Community Managed Services	2,775,362	3,311,053
4	Total State and Community Programs - GF/Formula Funding	$ 6,928,366	$ 8,136,459
B.	Categorical, Special And Designated Funds		
1	Respite Grant (Tobacco Tax)	$ 21,191	$ 21,191
2	Multicultural Services	34,521	34,521
2	Permanency Planning Grant	73,536	73,536
3	Total Categorical, Special and Designated Funds	$ 129,248	$ 129,248
C.	Subtotal - GF/Formula Community and State Managed Programs (A-B-C)	$ 6,799,118	$ 8,007,211

Schedule C
Contract Reconciliation and Cash Settlement Summary
October 1, 2003 through September 30, 2004

		Specialized Managed Care	Formula Funds
III.	Shared Risk Arrangement		
A.	Operating Budget - Exclude Categorical Funding	$ 29,993,828	$ 6,799,118
B.	MDCH Share - Exclude Categorical Funding	28,167,843	8,007,211
C.	Surplus (Deficit)	$ 1,825,985	$ (1,208,093)
D.	Redirect	-	-
E.	Shared Risk - Surplus (Deficit)	$ 1,825,985	$ (1,208,093)
F.	Risk Band - 5% of Operating Budget (A x 5%)	$ 1,499,691	$ (339,956)
G.	Sub-Total	$ 326,294	$ (868,137)
H.	Risk Band (Lesser of 2.5% of Operating Budget or 50% of G)	$ 163,147	$ (169,978)
I.	State Risk	$ 1,662,838 *	$ (698,159)
J.	Local Risk	$ 163,147	$ (509,934)

Schedule C
Contract Reconciliation and Cash Settlement Summary
October 1, 2003 through September 30, 2004

IV.	Cash Settlement		Approved Savings or	Redirected		Grand
A.	MDCH Obligation	MDCH Share	Carryforward	Savings	Total	Total
1	Specialty Managed Care	$ 28,167,843	$ 1,288,197 *	$ -	$ 29,456,040	
2	GF/Formula Funding (Net of Categorical)	7,497,276	-	-	7,497,276	
3	Categorical - MDCH Obligation	129,248	-	-	129,248	
	Total – MDCH Obligation					$ 37,082,564
B.	Advances – Prepayments					
1	Specialized Managed Care – Prepayments Through 9/30/2004			$ 29,993,828		
2	Specialized Managed Care - Prepayments after 9/30/2004			$ -		
3	Subtotal - Specialized Managed Care				$ 29,993,828	
4	GF/Formula Funding - (Include MDCH Risk Authorization)				2,646,114	
5	Purchase of Services				4,153,004	
6	Categorical Funding				129,248	
7	Total Prepayments					$ 36,922,194
C.	Balance Due CMHSP					$ 160,370
D.	Balance Due to MDCH for Unpaid State Service Costs					
	State Facility Costs				$ 4,825,406	
	Actual Payments to MDCH				4,823,841	
	Balance Due MDCH					$ 1,565
E.	Net Balance Due CMHSP					$ 158,805
	Prior Settlement (MDCH paid SCCMHA)					650,365
	Balance Due to MDCH					$ 491,560

***** Retention of additional Medicaid Savings of $374,641 ($1,662,838 - $1,288,197) as a result of audit adjustments contingent on inclusion in an approved Reinvestment Strategy as required by Section 7.7.2.1 and 7.7.2.2 of the MMSSSC.

Corrective Action Plan

Finding Number:	1
Page Reference:	4
Finding Title:	Differences Between the FSR and the Trial Balance SCCMHA did not report their revenues and expenditures correctly on the FSR as compared to the amounts stated in their trial balance, which is in violation of the MMSSSC and MMHSSC.
Recommendation:	Implement policies and procedures that include a reconciliation between the FSR and trial balance to ensure accuracy of the line items prior to submission to MDCH in compliance with the MMSSSC and MMHSSC.
CMHSP Comments:	Implementation of new clinical and general ledger software products have allowed us increased internal control and improved policies and procedures.
Corrective Actions:	Implementation of new software for increased control.
Anticipated Correction Date:	9/30/07
MDCH Response:	SCCMHA must take action to ensure there is a reconciliation between the FSR and trial balance to ensure accuracy of the line items prior to submission of the FSR to MDCH.

Corrective Action Plan

Finding Number:	2
Page Reference:	6
Finding Title:	Over Accrued MIS Costs SCCMHA overstated their management information systems (MIS) costs by $31,752.
Recommendation:	Establish policies and procedures to ensure accruals are more accurately calculated and adjustments for over or under accruals are more timely.
CMHSP Comments:	We disagree with this finding. The accrual was a result of disputed contract costs between SCCMHA and our MIS contractor. This was resolved in 2005 and reflected in our FY05 cost settlement.
Corrective Actions:	N/A
Anticipated Correction Date:	N/A
MDCH Response:	SCCMHA presented documentation that $3,716 of the $35,468 over accrual was reversed in the subsequent year. Consequently, the finding was reduced by $3,716.

Corrective Action Plan

Finding Number: 3

Page Reference: 7

Finding Title: Capital Assets Not Properly Depreciated

SCCMHA did not properly depreciate capital assets in compliance with Office of Management and Budget (OMB) Circular A-87 and contract provisions.

Recommendation: Adjust the useful lives of fixed assets in the depreciation calculation to adhere to AHA guidelines, and establish policies and procedures to use AHA guidelines in determining the useful lives of any fixed assets purchased in the future, in compliance with OMB Circular A-87.

CMHSP Comments: We disagree with this finding as written SCCMHA procedures and policies have been consistently followed in recognition of depreciation on fixed asset. AHA guidelines have never been used nor are they required by A-87.

Corrective Actions: N/A

Anticipated Correction Date: N/A

MDCH Response: Although AHA guidelines are not specifically required by OMB Circular A-87, the period of useful service established for depreciation calculation purposes must reasonably represent the useful life of the asset. SCCMHA established useful lives for their depreciable assets that were much shorter than industry standards (both AHA and IRS) as shown in the table below. SCCMHA must

adopt a reasonable standard for establishing useful lives for their depreciable assets and consistently apply it. Additionally, SCCMHA must exclude the cost of land in their computation of depreciation.

Asset Type	Useful Life SCCMHA	Useful Life AHA Guidelines	Useful Life IRS Guidelines
Office Buildings	15 years	25-40 years	25 years
Office Building Renovations	3 years	10-20 years	10-20 years
Group Homes	10-15 years	25 years	25 years
Land	15 years	NA	NA
Computers	3 years	5 years	5 years
Telephone System	4 years	10 years	7 years
Parking Lot	3 years	8-20 years	15 years
Drain Field	3 years	15 years	15 years

Corrective Action Plan

Finding Number: 4

Page Reference: 8

Finding Title: Improper Contribution to the Internal Service Fund

SCCMHA reported a $400,000 contribution to the Internal Service Fund (ISF) without evidence that the estimated liability in the ISF was based on sound actuarial principles using historical experience and reasonable assumptions as provided under OMB Circular A-87, which is in violation of contract provisions.

Recommendation: Adopt policies and procedures to ensure that any ISF contributions comply with contract provisions, and the ISF balance is analyzed and updated at least biennially as required by contract and OMB Circular A-87 provisions.

CMHSP Comments: We disagree with this finding as SCCMHA had completed this study for 2001 through 2003 and our risk exposure had not changed in 2004. The risk assumptions were realized in FY06, when we were required to use the entire balance in our Medicaid ISF, with the exception of the Coordinating agency's portion of the fund, to cover our Medicaid deficit caused by Medicaid rates rebasing for FY06 & FY07.

Corrective Actions: N/A

Anticipated Correction Date: N/A

MDCH Response: OMB Circular A-87 states, "*Contributions to reserves must be based on sound actuarial principles using historical experience and reasonable assumptions. Reserve levels must be analyzed and updated at least biennially for each major risk being insured and take into account any reinsurance, coinsurance, etc.*" SCCMHA last analyzed their ISF reserve on November 26, 2001. That study did not even cover FY 2003/2004; the year in which the ISF contribution was made. The actuarial study assumed that the ISF would be used to cover any risk financing for FY's 2000/2001, 2001/2002, and 2002/2003. Although the assumption may have been proper at the time, it proved to be inaccurate, as SCCMHA did not use the ISF to cover any risk financing until FY 2002/2003, and then only for Medicaid. The study also assumed that if no contributions were made the ISF reserve would be depleted by 9/30/2003. This also proved to be inaccurate. Changes in circumstances demonstrate the need to update the ISF studies periodically. OMB Circular A-87 requires that the update is done biennially. Thus, it would not be reasonable to allow contributions to the ISF reserves made in FY 2003/2004 based on an actuarial study done in 2001 that does not address the reserve requirements for that fiscal year.

Corrective Action Plan

Finding Number:	5
Page Reference:	10
Finding Title:	Lack of Monitoring of Consumer Funds SCCMHA did not implement and properly monitor effective accounting policies to properly account for resident funds at residential providers under contract, which is a violation of the Licensing Rules for Adult Foster Care Small Group Homes issued by the State of Michigan Department of Consumer and Industry Services (Licensing Rules).
Recommendation:	Establish and implement policies and procedures to ensure that resident funds are safeguarded against misappropriations by periodically reviewing resident funds, and by implementing punitive actions, where funds are not properly accounted for.
CMHSP Comments:	Procedures and policies have been put in place to monitor effective accounting policies to properly account for resident funds.
Corrective Actions:	In addition to the current annual audit of all residential provider handling of residential funds of the Event Verification audit, periodic audits will be implemented by financial staff.
Anticipated Correction Date:	9/1/07
MDCH Response:	None.

Corrective Action Plan

Finding Number: 6

Page Reference: 13

Finding Title: Inadequate Monitoring of Personal Care Services

SCCMHA was not effective in monitoring personal care services provided by the residential providers to ensure that personal care services were provided as required in the consumers' Individual Plans of Service (IPS), which violates the MMSSSC.

Recommendation: Establish and implement personal care policies and procedures to ensure that personal care services are provided in accordance with the IPS, in compliance with the MMSSSC, Attachment 6.8.2.4, and the Community Mental Health Services Program Manual, Chapter III.

CMHSP Comments: Saginaw CMH monitors approximately 200 placements in general adult foster care whose personal care services are authorized through the MDCH Single Sign-On System for placing agencies. This system was formerly referred to as Model Payments. This authorization function is managed by the SCCMHA Care Management Department, which requires case managers and supports coordinators to submit the MDCH 3803 form for prescription of services and the MDCH 2355 form for the authorization of services. SCCMHA has a written procedure for this function. Six professional staff have sign on security to the MDCH system. Training is provided by this department to all case managers and support coordinators in the network. All requests for retroactive authorization require supervisory sign off and review of medical necessity by the Care Management Department.

SCCMHA has also requested from MDCH access to management reports from the "Authenticare System." Reports which would detail current and expired authorizations as well as reports on payments made under authorizations issued by SCCMHA on the Single Sign-on System would be helpful in managing the volume of personal care authorized by SCCMHA. SCCMHA requested the ability to log on to the Authenticare System in communication with MDCH in August 2005, January 2006, and May 2006. However, we were advised by MDCH that the state had no plans to address the needed security levels in either the Single Sign-on or the Authenticare System, in order to provide management reports to authoring agencies, in the near future and that: "We (MDCH) asked DIT to write a mini program to allow access but with the pending changes in the overall system, nothing is going to change until they roll out the new system. At this point, single sign-on will be used for everything."

Corrective Actions: In lieu of live reports from the MDCH system, SCCMHA will develop a census and authorization system in the Encompass Information System. The SCCMHA Personal Care Policy will be revised by October 1, 2007 and training will be repeated in all departments by December 1, 2007.

Anticipated Correction Date: December 1, 2007

MDCH Response: Every two weeks MDCH sends reports to SCCMHA from the Authenticare System that include a status report by the name of client receiving a service, a payment analysis showing units of reported services provided, and a Model Payment Authorization.

Before authorizing payment, SCCMHA should ensure that the consumers are receiving personal care in accordance with their IPS.

Corrective Action Plan

Finding Number: 7

Page Reference: 14

Finding Title: Improper Personal Care Payments

SCCMHA was not effective in monitoring personal care payments for their consumers, which is in violation of the MMSSSC.

Recommendation: Implement effective monitoring policies and procedures to ensure that personal care services are provided for personal care payments received and to ensure that improper payments are refunded, in compliance with the MMSSSC.

CMHSP Comments: Monitoring payments is impossible without reports from the MDCH, either from the Authenticare System or from the Single Sign-on System. We re-iterate under this finding what was commented on in Finding #6.

SCCMHA has requested from MDCH access to management reports from the "Authenticare System." Reports which would detail current and expired authorizations as well as reports on payments made under authorizations issued by SCCMHA on the Single Sign-on System would be helpful in managing the volume of personal care authorized by SCCMHA. SCCMHA requested the ability to log on to the Authenticare System in communication with MDCH in August 2005, January 2006, and May 2006. However, we were advised by MDCH that the state had no plans to address the needed security levels in either the Single Sign-on or the Authenticare System, in order to provide management reports to authoring agencies in the near future and that: "We (MDCH)

asked DIT to write a mini program to allow access but with the pending changes in the overall system, nothing is going to change until they roll out the new system. At this point, single sign-on will be used for everything."

Corrective Actions: SCCMHA will again request county specific management reports from MDCH.

Anticipated Correction Date: Written request will be made to MDCH for electronic payment reports by June 30, 2007.

MDCH Response: Electronic access to Authenticare is currently not available to outside agencies. However, every two weeks MDCH sends reports to SCCMHA from the Authenticare System that include a status report by the name of client receiving a service, a payment analysis showing units of reported services provided, and a Model Payment Authorization. Before authorizing payment, SCCMHA should ensure that consumers are receiving personal care in accordance with their IPS. Additionally, SCCMHA must implement effective monitoring policies and procedures to ensure that personal care services are provided for personal care payments received and to ensure that improper payments are refunded, in compliance with the MMSSSC.

Corrective Action Plan

Finding Number:	8
Page Reference:	16
Finding Title:	Internal Control Weaknesses SCCMHA did not establish and implement effective internal controls to protect its assets.
Recommendation:	Establish and implement an adequate internal control system in compliance with the MMSSSC and MMHSSC that includes an annual inventory of furniture and equipment and the use of pre-numbered purchase orders.
CMHSP Comments:	SCCMHA considers this a good recommendation and will work to implement better internal controls on inventory of furniture and equipment, using our new software product.
Corrective Actions:	Complete inventory of furniture and equipment to be completed by 9/30/07.
Anticipated Correction Date:	9/30/07
MDCH Response:	SCCMHA did not address the lack of use of pre-numbered purchase orders and we continue to recommend their use.